

but to examine an exposed viscus or portions of viscera which could not possibly have been injured would be an error in practice.

11. The prognosis of wounds of the empty stomach is not necessarily bad.

12. Large accumulations of fat in the abdominal wall and cavity may sometimes contraindicate laparotomy for visceral wounds.—*Chicago Med. Journ. and Exam.*, July, 1887.

VI. Case of Recovery from Penetrating Gun-Shot Wound of the Abdomen, with Wound of Intestine, After Laparotomy and Suture of the Intestine. By T. A. McGRAW, M.D., (Detroit). Maggie McMahon, æt. 24 years, was shot in the abdomen at 3 o'clock on Tuesday morning, December 21, 1886. She was carried to St. Mary's Hospital at half past 8 o'clock, and I saw her at 9 o'clock on the same morning. I found her vomiting bile, and complaining of great pain. Her pulse was 120 per minute, her respiration 30 and her temperature 120°F. The bowels were moderately bloated and very tender, and two inches above and two inches inside of the right anterior superior spine of the ilium there was a gunshot wound with black edges. There was no tympanitic resonance over the liver, no extravasation of fecal matter, no enphysema, and no general meteorism. The pain was located in the hypogastric right iliac and right lumbar regions. The wound was supposed to have been made by a ball from a revolver of 32 calibre, although that point was never fairly settled. At 12 o'clock, noon, I cut through the abdominal wall at the site of the wound, by making an incision of four inches long in the direction of the fibres of the external oblique muscle, the wound being in the centre of the incision. It was easy to trace the wound into the abdominal cavity by the discoloration of tissues, and it soon became evident that the ball had passed from before backwards, and from above downwards, into the peritoneal sac. My finger, on entering the cavity, immediately detected a hole on the anterior surface of the ascending colon, which I thereupon drew out on to the abdomen. This wound, from which the fecal matter was constantly pouring, was an oval with its long axis transverse to that of the intestine. It was about half an inch long and a quarter of an inch wide. I sewed it up with a continuous suture of catgut, in a double

row, after Czerny's modification of Lembert's method. Searching then for the wound of exit, I found it also vomiting fæces directly behind at the junction of the meso-colon with the intestine. The meso-colon and meso-cæcum in this case were long as the peritoneum completely surrounded the gut. The ilium was united to the intestine on its inner and posterior surface midway between the two wounds. The second wound had its long axis also transverse to that of the bowel, and was sewed together in the same way as the first. This done, I was able to trace the track of the bullet down into the femoral canal before the external iliac and femoral artery, by a ragged opening in the muscle, but its course afterwards is a matter of great uncertainty. I carefully examined the small intestines without withdrawing them from the cavity, but found no other wound. The abdominal cavity was washed out and closed with wire sutures, and a drainage tube inserted. The patient began immediately to improve, and her temperature fell a degree on the same day; she vomited less frequently, and the ejecta contained only mucus and swallowed fluid. Her pulse fell to 100, but her temperature rose again on the second and third days to 102° F. After the third day the improvement was more marked, and on the sixth day she ceased altogether to vomit, and her temperature fell to 99° and 100°. The drainage tube was then withdrawn, without having discharged one drop of pus. Subsequently, however, a small superficial abscess formed in the track of the wound, and on the tenth day discharged a teaspoonful of pus. Her convalescence was thenceforth uninterrupted, and she left the hospital, February 2, suffering only from a lameness consequent upon the passage of the ball into the thigh.—*Chicago Med. Journ. and Exam.*, July, 1887.

VII. Laparotomy in Perityphlitic Abscess with Especial Reference to Perforation of the Appendix Vermiformis. By ROBERT F. WEIR, M.D., (New York). This paper is a plea for earlier operation and bolder treatment in this class of cases, and contains a critical review of the literature of the subject and an analysis of the ten reported cases of operation for infectious peritonitis for perforation of the appendix vermiformis, which may be tabulated as follows :